PROGRESS

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IN THIS ISSUE

AWARENESS · KNOWLEDGE · UNDERSTANDING
PREVENTION

THE ALCOHOLISM FOUNDATION OF ALBERTA

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The Alcoholism Foundation of Alberta is a private Foundation incorporated in 1951 under the Societies Act, financed by provincial and municipal grants, corporate and private contributions. The Foundation's three point program of Education, Treatment, and Research, is directed at the eventual Prevention of Alcoholism in Alberta. Patient counselling, medical, educational, and research services are provided through the two centres in Edmonton and Calgary. The Foundation recognizes alcoholism as a treatable illness, a serious public health problem, and therefore a public responsibility.

TREATMENT

Treatment services are available to anyone desiring help with a drinking problem. The treatment program includes individual counselling, medical treatment, and group therapy. A service fee of $10.00 is charged to the patient. No patient is ever denied treatment due to inability to pay.

There are no consulting fees.

Edmonton and Calgary out-patient clinic hours — 9 a.m. to 5 p.m.
Monday through Friday.

The Alcoholism Foundation of Alberta

Executive Director - MR. J. GEORGE STRACHAN

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Dr. E. M. Jellinek at Seventy

DR. E. M. JELLINEK, who is celebrating his seventieth birthday this summer, is at the present time Chief Consultant to The Alcoholism Foundation of Alberta. We at the Foundation think it fitting that this issue of Progress be dedicated to Dr. Jellinek in appreciation of his incomparable achievements in the field of alcoholism.

Prior to 1939 when Dr. Jellinek joined the newly-founded Research Council on Problems of Alcohol, he had achieved a reputation as a biometrician. The outstanding accomplishment of the Research Council was its sponsorship of a 'Study of the Effects of Alcohol on the Individual.' Dr. Jellinek was the Executive Project Director of this study which took the form of a critical review of the medical-psychological literature, and later developed into the book *Alcohol Addiction and Chronic Alcoholism,* of which Dr. Jellinek was Editor and chief contributor.

In 1940 Dr. Jellinek joined Dr. H. W. Haggard at the Laboratory of Applied Physiology at Yale University. This was later renamed the Laboratory of Applied Biodynamics, out of which evolved the famed Center of Alcohol Studies. Dr. Jellinek soon became Associate and later Managing Director of the Quarterly Journal of Studies on Alcohol, and founded the Yale Summer School of Alcohol Studies, directing its development during its first seven years. He also established the Yale Plan Clinic, which has since been a model for numerous alcoholism treatment programs.

In 1950 The World Health Organization appointed Dr. Jellinek their Consultant on Alcoholism. From the WHO Subcommittee on Alcoholism there developed new studies, writings, international meetings and seminars. In 1956 Dr. Jellinek resigned from WHO and returned to America.

In his seventieth year Dr. Jellinek is still seeking and fulfilling new rôles. Late in 1959 he was appointed Honorary Clinical Professor in Psychiatry by the University of Alberta, where he is teaching and developing courses on alcoholism. He continues to lecture at the Yale Summer School of Alcohol Studies. His book, *The Disease Concept of Alcoholism,* is to be published in the Autumn. He has been appointed a member of the Co-operative Commission on the Study of Alcoholism. He is currently General Consultant, The Alcoholism Research Foundation of Ontario, and Chief Consultant, The Alcoholism Foundation of Alberta, where he is sharing his unequalled fund of knowledge in lectures, discussions, consultations, and reports. The staff of the Foundation are using his encyclopedic knowledge to good advantage, and the warmth of his personality endears him to us all.

We join the *Quarterly Journal of Studies on Alcohol,* which, in its introduction to the E. M. Jellinek Jubilee Volume, March 1960, says, "With this salute to E. M. Jellinek in recognition of past achievements goes the wish that he may long continue in the work that he does best of all — the proliferation of ideas."

T.G.C.

GOALS OF ALCOHOLISM PROGRAMS

By E. M. Jellinek, Sc.D.

An address to the Seventh Annual Membership and Board Meeting of The Alcoholism Foundation of Alberta, May 18th, 1960.

Mr. President, ladies and gentlemen:

CLOSE TO 2,400 years ago, the philosopher Plato wrote in his 'Laws' that as soon as the question of drunkenness is broached "some fall to praise it and others to revile it." He added that he would not care to discuss institutions in this manner, indicating the need for objectivity in dealing with the questions of drinking and drunkenness. Plato also recognized the complexity of the problems arising from the use of alcoholic beverages when he said, "It takes no mean legislator to deal with the question of drunkenness."

In our day, Plato is being quoted nearly as frequently as some of our statesmen and politicians, and the world has learned much from him, but apparently his remarks about the need for objectivity in the discussion of this problem and his warning about its complexities have been overlooked until very recent times.

Systematic approaches to the problem of alcoholism had their beginnings some one hundred and fifty years ago, but the thinking of governments and the public at large about this matter was characterized by over-simplifications, clumsiness, and the idea that "nothing can be done about a drunk." The latter contention has been shown to be invalid through the activities of the fellowship of Alcoholics Anonymous and by public and voluntary alcoholism clinics. The over-simplifications have been successfully attacked by the work of a Yale University group of scientists who organized an elaborate, multi-disciplined approach to the problems of alcohol.

The activities of Alcoholics Anonymous and of the Yale Group with its researches and pilot clinic

have had wide repercussions. As a result, alcoholism programs of voluntary agencies, such as the National Council of Alcoholism, state alcoholism programs in the United States, and provincial government programs in Canada, have been established.

In Canada, seven provincial governments are operating such programs, either as crown corporations or as government subsidized voluntary agencies. Five of these programs are in full operation and two are beginning activities. In the United States, forty state government programs have been established, a few of which are only "on the books." There are also some local government programs (county and municipal) and more than fifty voluntary organizations affiliated with the National Council on Alcoholism. There must be mention also of denominational programs, which have undergone great revision under the impact of the scientific activities of the past fifteen or twenty years and through contact with Alcoholics Anonymous.

MOST OF THESE programs, whether governmental, semi-governmental, or private, designate in their briefs that their goals are treatment, education, research, and prevention. These seem to be simple, straight-forward statements of goals, but when it comes to reaching these goals it turns out that the means are complex and the ways circuitous. Unexpected problems arise and there are hundreds of side issues, some of which are large and difficult.

The logical procedure would seem to be to discuss these goals one by one. They are, however, so overlapping that I doubt if they can be discussed isolated from each other.

At the Eleventh Annual Meeting of the North American Association of Alcoholism Programs, which is to be held this year in Banff, members have suggested questions for discussion. One of the questions is, How does one integrate clinical, educational and research activities? I venture to submit that this is a poor question. The questions should be not how to integrate these activities, but rather how to avoid their arbitrary separation, and I cannot refrain from saying that such arbitrary separation has often been the case. After eleven years of the existence of the N.A.A.A.P., fifteen years of activity of some of the member agencies, many avenues of approach are still not clearly seen. This lack of clarity must not be attributed to faults in administrative leadership, but to the magnitude and complex structures of the problems with which the leaders are faced.

The creation of treatment centres in a province or state is only the first approximation to the goal of prevention. Of course, there have to be first, pilot undertakings in which treatment is tested, but the ultimate goal must be to provide treatment for all alcoholics in a province or state.

Let us assume that government or private donors, or both, would supply the funds for fifteen treatment clinics in a given province. Would the cash solve the problem? What difficulties would arise and what new goals would emerge from these difficulties?

First of all, it would not be possible to staff those clinics on account of the extreme shortage of specially trained personnel. The recognition of this fact leads to one branch in the field of education, namely, professional training to supply staff for future clinics. But, even the fifteen clinics would not suffice; and as one cannot multiply clinics in infinity, one would also have to see to it that every general hospital should be willing and able to provide treatment for alcoholics. Such a goal involves consultation services and the extension of professional training to hospitals outside of agencies entrusted with the alcoholism program. Let us assume that we develop this large external and internal staff. Does that assure us that we shall bring treatment to all alcoholics? We may have the physical facilities and trained staff and then find that the alcoholic patients are not coming in sufficient numbers.

At the treatment centres in Edmonton and Calgary, and the two budding services at Lethbridge and Medicine Hat, we serve all the patients we can handle, but I doubt that if our treatment staff were multiplied by fifteen, the number of patients would be multiplied even by three or four. After all, Alcoholics Anonymous with all its phenomenal development does not reach more than two-tenths of one per cent to five per cent of all alcoholics in a given territory.

WHY DON'T ALL alcoholics come to treatment? Why not even one-tenth of them? One might surmise that, in spite of very great efforts, the idea of alcoholism as a disease and its treatability is not sufficiently propagandized. We need education of the public on a very large scale in order to make them utlize the expanding facilities. This is not just a matter of talking louder and more frequently and distributing more pamphlets. We are up against problems of language, problems of communication. I do not think that we know how to communicate really effectively about alcoholism except to small segments of the alcoholic population and their relatives.

We use the language of Alcoholics Anonymous and we use what we believe to be a popular version of the language of clinicians and research men. But do the words we use mean to the public at large, and particularly to the alcoholic population and their family, what they mean to us? I have great doubts about it. As a matter of fact, communication on alcoholism is difficult enough between clinicians and research men, between clinicians and A.A., and even within the guild of clinicians or within the guild of research men. Evidence of this difficulty is the multiplicity of definitions of alcoholism and of such terms as tolerance, sensitivity, craving, compulsion, and so on. There is even possible misunderstanding about such apparently simple terms as treatment and program. The word program means one thing to members of A.A. and quite a different thing to administrators of provincial and state alcoholism programs. Thus there may arise in A.A. a feeling that governmental and private agencies are either usurping the A.A. program or are

developing something which conflicts with it.

In order to propagandize the idea of the treatability of alcoholism and in order to get large masses of alcoholics to accept treatment, we must find more effective words; or rather, certain sets of words for each section of the population. That is, we need research on the subject of communication about alcoholism. This matter about communication becomes of the greatest importance when we wish to engage the interest and co-operation of all community facilities in a concerted effort toward the rehabilitation of alcoholics on a large scale. You see, we cannot talk about treatment goals without considering educational and research activities.

I HAVE brought this up as an example and I cannot go on enumerating all the complications in reaching the goals, but there are three points which I should like to touch upon briefly. The first is the goal of prevention of alcoholism; the goal to which the least progress has been made.

It has been said frequently that the treatment and rehabilitation of alcoholics involve an element of prevention. This is true, but it is a limited contribution. The various alcoholism clinics, which at present are, of course, not numerous enough and work with small budgets, and the wide-spread facilities of Alcoholics Anonymous, have achieved to date no more than a reduction in the rate of increase of alcoholism.

What is required is a well devised systematic program of prevention which would cut down the need for endless expansion of treatment facilities. This matter has been left entirely to preventive education. But this is far too narrowly conceived. It does not suffice merely to describe the process of alcoholism and to teach that it is an extremely wide-spread, but treatable disease. No doubt such propaganda is very necessary and has its influence, but it is far from adequate.

Preventive action must emanate from a knowledge of drinking customs and attitudes toward drinking. Such knowledge, of course, must be produced by research which has at present only scratched the surface. In the case of treatment, there exists a respectable, if not sufficient, fund of knowledge which can be applied, but in the matter of prevention, such knowledge is largely lacking. When such knowledge becomes available, research will then have to find the most effective way of communication.

I should like to add that there is a tendency among the activists in this field to ignore the question of legal controls of the consumption of alcoholic beverages. While it is true that many legal controls are ill-conceived, not enforceable, and have little effect, there is evidence that some can contribute toward the reduction of excessive consumption. The recent loosening of such controls in Sweden has resulted in a considerable increase of alcoholism in that country. While the devising of legal control measures is not within the province of alcoholism programs, they can, nevertheless, have an advisory role without being drawn into propaganda.

THE NEXT point I should like to make concerns a secondary, but important and cogent, objective; the assessment of the impact made by alcoholism programs. In the follow-up studies of patients of alcoholism clinics, a start has been made, and revealed considerable technical difficulties. Other measures of the impact have been rather unsatisfactory ones, such as the number of pieces of literature distributed, the number of newspaper releases, talks, radio and TV programs. In order to measure impact made by the various agencies in this field, it is necessary to find out what people know about the activities, the objects, and the methods of the agencies in their communities, province or state. The question should be, Who knows what about this or that agency? What does the corner grocer know and what are his attitudes towards those activities? What do taxi-drivers know, school teachers, journalists, physicians, the so-called average man, etc.? All this can be found out through well devised research techniques only. Such investigations will, by the way, also contribute something towards our understanding of better communication.

LASTLY, I should like to call attention to the fact that alcoholism programs develop their activities within a very definite environment and a definite climate. That climate of opinion is generated by the existence in that environment of temperance societies, welfare agencies, various social programs, health programs, vested interests, Alcoholics Anonymous, etc., and sections of the general population whose attitude towards the problem of alcohol may be indifference, ignorance, and, in a small section, some degree of acceptable understanding. This latter section has been growing in the past fifteen years, quite considerably, but it is still rather small. While according to surveys a large proportion of the general public is inclined to accept the idea that alcoholism is a disease, their ideas about this are nebulous. They may answer the question whether alcoholism is a disease as "true," but deep down they may still feel that this is not **REALLY** true!

The activities of the alcoholism programs may generate considerable anxiety and therefore a certain kind of opposition in various interest groups and segments of the population. We must learn, therefore, to demonstrate that the anxieties are unfounded.

What I have said here should not be regarded as discouragement. The difficulties and obstacles are by no means unsurmountable, but in order to surmount them, one first has to be aware of their existence.

A PATIENT'S VIEW

OF THERAPY

BY A FORMER FOUNDATION PATIENT

I CAME through the doors of the Foundation completely bankrupt—socially, financially, and domestically. I had been talked at by many people: family, employers, social workers, nurses, doctors, ministers; but it was not until I reached the Foundation that I met anyone who seemed to be able to understand my problem. The Foundation counsellors accepted me as I was: good and bad, strengths and weaknesses. I was wallowing in self-pity, yet they did not wallow with me. I was financially in extremely bad shape, but there was no quick hand-out. I was hostile to the whole world, and was given the opportunity to verbalize as much hostility as I cared to. My counsellor patiently listened to it all with no indication as to whether I was right or wrong. This was the way I felt and the way I felt was important. I projected my feelings and my sorry plight in a hundred different directions, and each was accepted, discussed, and then I was allowed to come to my own conclusions. There was a great deal of guidance, but I was never allowed to become too aware of it.

This took time, and time is a significant factor in the recovery of an alcoholic. He cannot tolerate hurry and pushing in other people, because people have so little time for him. The first person who gives the alcoholic the time to pour out his feelings, who listens to his hostility and projection, is going to be able to build a relationship that can later be used in a therapeutic way.

Most of the alcoholics I know are basically intelligent people, and, what is more important, people who have a keen ability to sense the feelings and attitudes that are radiated by those they meet. The active alcoholic's whole life is one great wall of defence to protect him at all costs from the realization of what he is doing to himself. He has experienced the constant attempt of people to break through his rationalization system, until he is continually on guard and extremely quick to take offence as a weapon of protection. The least hint of criticism and he retreats into his shell of defense. His energy is used in developing defenses, rather than developing himself.

The active alcoholic cannot be expected to react to logic or common sense. He is in the peculiar position of being very sick without knowing it; for he is always the last to realize he is alcoholic. He shows none of the physical symptoms apparent in other illnesses, yet there are recognizable symptoms in every area of his life. If these symptoms (gross rationalization, chronic irrational behaviour, extreme irrespon-

sibility, etc.) appeared without the uncontrolled drinking, we would immediately realize that there was something seriously wrong and we would be quick to urge the alcoholic to seek treatment.

Yet with alcoholism, there is a tendency to sit back and allow the condition to carry on year after year without realizing that unarrested alcoholism, because of its progressive nature, can only end in one of two ways: death or insanity. Ironically, alcoholics themselves were the first to find the answer to their own problems, and Alcoholics Anonymous was born out of their own need. Since that birth, much has been learned; treatment techniques have been developed, theories have been put forth, and a great deal of research has, and is, and will be carried out. But no matter how much we learn, one basic factor still remains. The suffering alcoholic must be approached with knowledge, warmth, and understanding to bring him to recognize his illness, and then his need, and right, and obligation, to seek treatment and stick with it.

The Alcoholic and His Work

By the time I applied to the Foundation for treatment, I had had and lost many jobs. Because of my irrational behaviour and frequent absences, I was criticized and abused by employers, with no defence that had the slightest chance of being accepted. I was warned, threatened, and sacked repeatedly, and had to approach the next prospective employer with little or no recommendation. Through necessity I had to lie and cheat in order to secure employment, and then work under the strain of being found out. I carried the anxiety and tension that were built up inside me, until the pressure became so great that I had to have some type of pain-killer. What was the type I knew best? Alcohol. I used rationalization to justify that first drink, only to rediscover that one drink was too many and a hundred not enough. So started the same old routine all over again, until fear and tension became so strong that I began to question my own abilities. My self-confidence would be so threatened that when I applied for a job, it was with an apologetic, negative air; until the day came when I quit trying and began to use my alibis to avoid seeking employment at all.

The Alcoholic and His Family

Many wonder why so many wives stick with their alcoholic husbands through untold misery. A common remark is "If I were that woman I wouldn't stay in the situation five minutes." Why do families stay? I think it is because the alcoholic is basically an average human being with all the warmth, kindness, understanding, humor, wit, and pathos, that make up a worthwhile person. Because of the nature of the illness, his personality appears to be greatly changed and defences and rationalization take the place of many normal emotions. Extensive and intensive periods of intoxication weaken emotional controls and exaggerate some personality characteristics, and so starts the typical Jekyll and Hyde behaviour of the alcoholic. Yet, throughout his alcoholism, there are still bits and pieces of his personality, the

parts that once endeared him to his family still breaking through: promises of hope that some day the original father or husband, son or daughter, may come back bringing happiness to the family once again. You must remember we were not always alcoholic. Once we had all the ingredients of a good life, and memories of happiness are longer than those of unhappiness.

What were my feelings when I thought about my family? "Why do I hurt them so much when hurt is not intended?" "Why do I let them down when I mean with all my heart to keep my promises?" "Why do I neglect them when the best is none too good for them?" These are the agonies that many alcoholics experience in the hangover period and sober periods that follow the prolonged benders. How could we forget these people we love during our uncontrolled drinking periods? We do it because we are sick and cannot accept our illness. We do it because of the confusion our illness creates, not only for ourselves, but also for the people who are close to us. We carry on in our illness because we cannot understand that treatment and resulting sobriety will remedy most of the complications that appear to be the illness, rather than the results of the illness.

MANY alcoholics become completely dissocialized, as I became, and our families must share this with us. Why do we feel this dissocialization so greatly? I believe it is because it signifies the loss of the most precious ingredient of all, human dignity. Perhaps because the alcoholic has experienced this loss, when he once again is restored to health he becomes a real asset to our society through the understanding of his great need for the love and respect of his fellow man. Perhaps, too, this loss of self-respect and the respect of others is the greatest barrier to his seeking treatment for his illness, so that those who are trying to help

him must, from the beginning, try to restore some spark of his human dignity. It is a terrible feeling to hate yourself utterly and completely, and be so consumed by this self-loathing that you completely cut off all other human relationships.

Many can help alcoholics seek treatment, by understanding the nature of alcoholism, by giving the alcoholic sympathy and understanding, and at the same time by dealing with him in a constructive way.

The alcoholic resents what he considers sham criticism. He is fully aware of the repercussions of his behaviour, his present lack of responsibility on the job and with his family. He does need intelligent, humane understanding, combined with knowledge and awareness, to help him recognize and accept his illness. This I found in the Foundation's program. With the completion of therapy at the Foundation, I was introduced to Alcoholics Anonymous and joined the group of my choice. So now I have my A.A. activities and also the continual support of all the staff of the Foundation. This team has kept me sober for five years; and not only sober, but happy and contented, and leading a meaningful, useful life as well.

Group Therapy At The Foundation

By J. D. M. BLISS

THE PROCESS of treatment and rehabilitation of any individual suffering from a serious illness often involves the services of a number of professional disciplines. The illness, alcoholism, is no exception to this general rule. As in other illnesses, the practitioners usually involved include a physician, a nurse, a psychologist, a social caseworker, and often a group worker.

The treatment team at the Foundation[1] consists of a doctor, a consulting psychiatrist, a nurse, and counsellors. Foundation counsellors all have extensive training in psychology or social work. Treatment involves not only the counselling of individual patients, but also regular group sessions during the evenings. Occasionally a special group for wives of alcoholics is held in the afternoons.

Group methods, though many and varied, have a well established place in social and therapeutic interaction among individuals. In the treatment of many illnesses, group methods have permitted new approaches to modifying or changing the intellectual and emotional distortions of reality so common among patients. Such distortions, if they persist, may lead the patient into increasingly unhappy and unsatisfying inter-personal relationships.

Because the progression of alcoholism is usually accompanied by decreasing ability to relate to others, group methods are an important adjunct to other forms of therapy in treating the alcoholic. In the early stages of alcoholism this isolating process may be experienced by the patient as a feeling of reluctance to meet certain people or to attend certain functions without the "support" of a drink or two.

As the illness progresses, the isolation process, expressed as a breakdown in the alcoholic's ability to talk things out with others, may become more and more apparent to everyone with whom he has contact. As a result, when the problem has reached proportions serious enough to merit referral for the treatment of his alcoholism, the long term treatment must include an emphasis on the reversal of this process of isolation and must improve the patient's ability to communicate effectively and satisfyingly with others.

EXPEDIENCY dictated the use of group methods in the early days of the Foundation's program. By March 1954, the pressure of patient intake made greater de-

mands upon counsellors than could be met by counselling individuals. Secondly, treatment of a patient meant a great change in his habit pattern and evening groups seemed to give the kind of support needed to maintain sobriety in the early stages of treatment.

At first groups were held four nights a week. The approach was educational and little participation was expected from the patients during the first series. The areas covered in these four nights were: the illness alcoholism, the phases of alcoholism, the emotional factors in alcoholism, and an introduction to A.A. given by a member of that fellowship.

It was not very long before the pressure of giving talks lasting one and a half to two hours, four nights a week, brought about a modification. Early in 1955 the group material was subdivided and enlarged with the addition of two talks, one on the physiological aspects of alcoholism and the other on theories of the causes of alcoholism. Since that time there has been an ongoing process of modification of the content of the Initial Group material.

Some of the aims which it is expected will be achieved by patients' participation in the initial groups are:

1. To teach patient and family facts about alcoholism as an illness;
2. To break down prejudices and misconceptions about the alcoholic, thereby reducing damaging threats to his self-esteem;
3. To pave the way for a reversal of the isolating process;
4. To help the alcoholic and family realize that others share their problem;
5. To provide an accepting group atmosphere for new patients; and
6. To help reduce overwhelming feelings of guilt and anxiety which, because of their intensity, have prevented the alcoholic accepting help from others. The patient is thereby helped toward an understanding of his past seemingly irrational and destructive behaviour.

September 26th, 1955 marked the beginning of a second level of group work at the Foundation. The Intermediate Group was designed as a multi-purpose group. Following are some of the aims of this group:

1. To reduce the patient's resistance to group participation in places and situations where alcohol may or may not be used;
2. To help, through the group interaction, breakdown feelings of isolation;
3. To fortify the patient with knowledge about himself and his illness, alcoholism;
4. To help develop or re-learn the ability to communicate with others and to express real feelings and attitudes without having to "cover up";
5. To help patient and family learn to communicate with one another without resent-

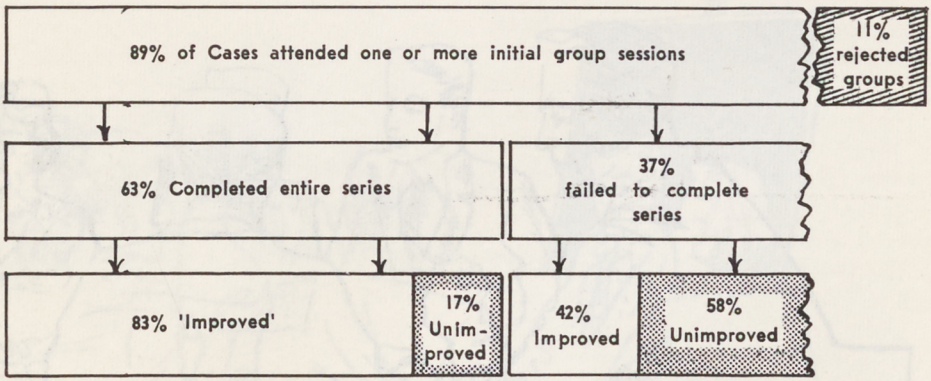
ment and the attendant belittling attitudes and recriminations;

6. To strengthen the patient's motivation toward continuing sobriety by helping him identify and clarify damaging feelings and attitudes; and
7. To suggest more constructive ways of dealing with such feelings as anxiety, resentment, tension, frustration, self - pity, self - justification, etc.

Although patient participation in discussion was one of the major aims, it was soon recognized that the recovery for most patients was too early to place full responsibility for the program on the patients. Although it was felt that the group process itself was more important than the content, a partly structured approach was used in which the group leader exercised a certain amount of control and direction.

BOTH TYPES of groups started as patient groups only, but, in 1955, spouses were encouraged to attend each of the groups. This change was a success from the first. The response to the group material and to group interaction as expressed by improved relations and greater ability to communicate between husband and wife indicated

INITIAL GROUP ATTENDANCE AND RESPONSE TO TREATMENT



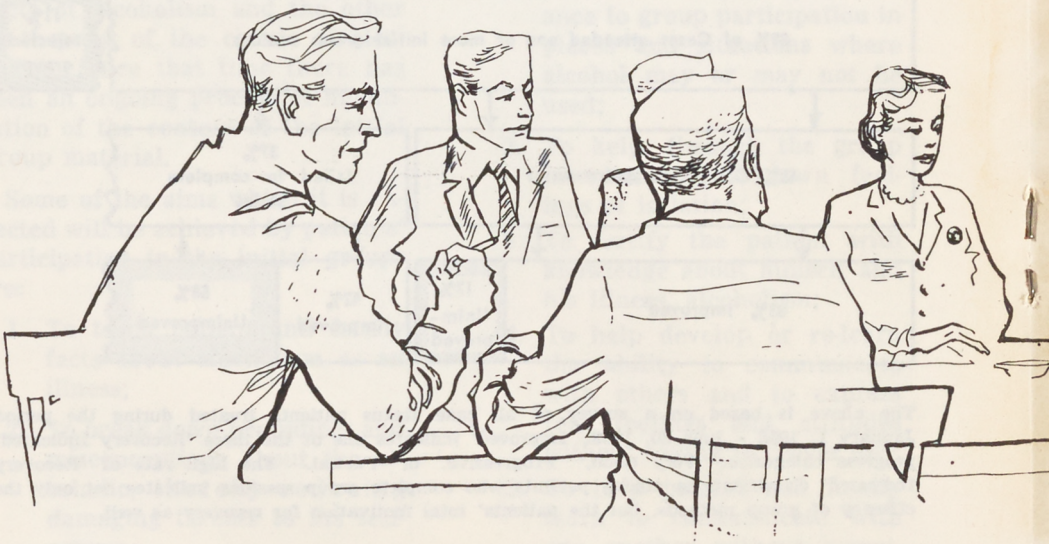
The above is based on a survey of all case status patients treated during the period January 1, 1958 - June 30, 1959. 'Improved' indicates one of the three 'Recovery Indicated' progress categories: 'Very Good,' 'Progressive,' or 'Partial.' The high rate of 'Recovery Indicated' classifications among patients who complete group sessions indicates not only the efficacy of group methods, but the patients' total motivation for recovery as well.

that a definite reversal in the isolating process had been effected.

During 1957 the idea of breaking the intermediate group into two or three discussion groups containing five or six individuals was introduced and is still being carried out.

The group meets as a whole for fifteen to twenty minutes during which a topic relative to alcoholic behaviour is introduced. Charts, films, and slides are used as much as possible. A very brief question period follows, after which the large group is broken into several smaller discussion groups, with the spouses deliberately separated. Twenty-five to thirty minutes is usually allowed for discussion, although this frequently extends five or ten minutes longer. The whole group then reassembles. The conclusions of the small groups are discussed. If time allows, the topic for the next meeting is suggested. The intermediate group meets once a week for a period of from eight to twelve weeks.

Several attempts have been made to have a third level group in which the topics and the entire group process would be conducted and controlled by the group itself. At the beginning, a Foundation counsellor acted as a group leader. When the counsellor withdrew, however, in each instance the group ceased to function. It is difficult to pinpoint all the reasons why the group did not and could not continue on its own with leadership coming from within the group. Perhaps at this level a fully-trained group leader might have helped the group make the transition to leadership from within. It may be that the depend-

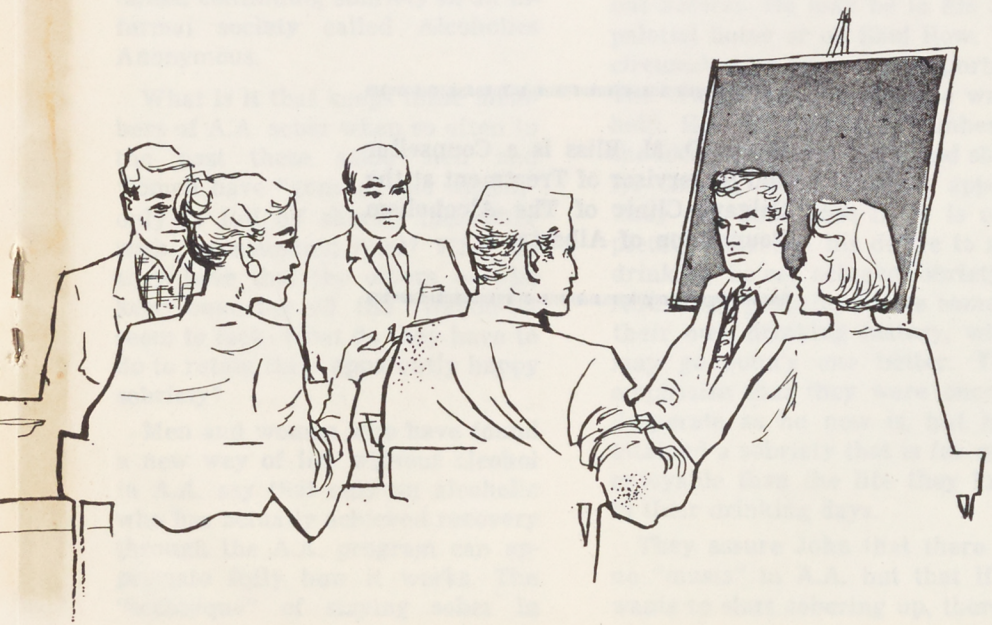


ency needs of the members of the three groups in question were still too great to allow them to feel comfortable functioning on their own. Perhaps the fact that the majority of members in these groups were by that time successfully integrated into Alcoholics Anonymous made them unconsciously less willing to try to make this group function even though it was formed at their request. Be that as it may, the possibility of third level groups will be explored further.

Wives of alcoholics have been counselled in group meetings at the Foundation. Since wives of still practising alcoholics were included with wives of alcoholics who had already achieved some months of sobriety, there was naturally a different focus in the questions individual members directed to the group leader. As a result the composition of subsequent wives' groups will take this problem into consideration.

At the present time, two levels of groups are being conducted: the Initial Group held two nights a week for three weeks with the series being repeated every fourth week; and the Intermediate Group, 'graduates' from the Initial Group, held once a week for from nine to twelve weeks. These groups, in conjunction with individual counselling for the practising alcoholic and, where indicated, with the spouse, are of great value in the total treatment and rehabilitation process.

IN SUMMARY, group methods by the Foundation in the treatment of the patient suffering from



the illness, alcoholism, have evolved to meet the needs of the recovering alcoholic and to help him meet the exigencies and stress of a life without using alcohol. The Initial Group is didactic in its content and while group participation is not expected, questions are encouraged. The educational approach provides the patient and spouse with new concepts about alcoholism as an illness, permits destructive feelings of guilt to be reduced, and offers a logical explanation for seemingly irrational behaviour as a guide to recovery.

The Intermediate Group carries the above process further by promoting constructive interaction between patients and spouses, between group members, and by helping them to evaluate and to learn how to change damaging feelings and attitudes. The increasing participation in the groups helps the members learn new methods of interaction as well as providing clues for integrating the new concepts into their total life pattern. Damaging dependency patterns are identified, discussed, and discouraged, and constructive interpersonal relations are encouraged.

REFERENCE

1—See Fraser, A. W. "The Treatment Team Approach" **Progress**, Vol. I, No. 2, Sept. 1959, p. 26.

Mr. J. D. M. Bliss is a Counsellor and Supervisor of Treatment at the Calgary Clinic of The Alcoholism Foundation of Alberta.

ALCOHOLICS ANONYMOUS

—*How The A.A. Member Stays Sober*

THE EXCESSIVE drinker who swears off alcohol "for life" and then falls flat on the barroom floor a few nights later is a pathetic figure in the folklore of many peoples. For centuries the problem drinker has baffled the best efforts of relatives, friends, doctors, and spiritual advisers — all devotedly eager to help him, if only they could.

During the past twenty-five years, a new phenomenon has appeared in the annals of compulsive drinking. It is the fellowship of more than 250,000 once-hopeless drunks who somehow have achieved and maintained continuing sobriety in an informal society called Alcoholics Anonymous.

What is it that keeps these members of A.A. sober when so often in the past these same men and women have "gone on the wagon," only to fall off shortly thereafter with a resounding thud? What do they have that the others — who keep bouncing off the "wagon"— seem to lack. What do they have to do to retain their apparently happy sobriety?

Men and women who have found a new way of life without alcohol in A.A. say that only an alcoholic who has actually achieved recovery through the A.A. program can appreciate fully how it works. The "technique" of staying sober in A.A. is deceptively simple, they say; you just "stay away from the first drink."

But how does the "successful" member avoid the kind of relapses he suffered so often in the past? "He is still the same person, isn't he?" ask the skeptics.

Here are some of the answers to this question and to others that might be summed up as: "How does the A.A. member stay sober?"

Assume that John Doe is a typical problem drinker who has finally come to the end of his rope. He wants to stop drinking. But he has tried to stop time and again, without success. He may be in his own palatial home or on Skid Row. The circumstances are not important. The crucial thing is that he wants help. He calls the A.A. number in the local telephone book, and shortly, one or more visitors appear. They tell John that if he is completely honest in his desire to stop drinking, he can achieve sobriety in A.A. They probably recite some of their own drinking history, which may go John's one better. They emphasize that they were once as desperate as he now is, but have attained a sobriety that is far more enjoyable than the life they knew in their drinking days.

They assure John that there are no "musts" in A.A. but that if he wants to start sobering up, there is

no time like the present. They offer to take him to the nearest meeting of an A.A. group. John may hesitate, but if he really wants to get sober, he soon finds himself in a meeting. The people he is introduced to represent a cross-section of the community.

AT THIS MEETING John probably hears two or three speakers and a man or woman who leads the meeting. He may not grasp all that is being said but he gets a definite impression that the speakers once were drunks and no longer drink. He hears what appear to be a number of catch-phrases. After the meeting, he asks his "sponsors" a question.

"What are the Twelve Steps?"

He learns that the Twelve Steps, which are "suggested" only, are simple statements of the actions and mental attitudes of the early members of A.A. who recorded their personal experience in achieving sobriety years before the society even had a name. The first step, he is told, is the admission that the alcoholic is powerless over alcohol, that his life has become unmanageable. He can agree with that. His life certainly had not been too manageable.

The other Steps cover such matters as the alcoholic's being willing to turn his life over to the care of a Power greater than himself . . .

John may protest: "None of that religious stuff for me!"

His sponsors explain that A.A. is not a religious program in the denominational sense. God, in A.A., is always God, *as the alcoholic understands Him.* They suggest that alcohol was a power greater than John during the days when he was unable to control it. Doesn't it make sense to depend, not on alcohol, but on some constructive power that can help him? John may waver. "Then why not consider the local A.A. group your Greater Power? It can help you do what you say you want to do but can't handle yourself—it can help you stop drinking."

"What was this 'Twenty-four Hour Plan' one of the speakers mentioned?"

John's new friends explain that this means the A.A. member doesn't take any pledges, doesn't go on the wagon. He simply applies the proved principle that any drunk can stay away from alcohol for twenty-four hours at a time. And since nothing can be done about yesterday, and tomorrow never comes, the current twenty-four hours is all John has to worry about. Does that make sense to him?

It does. John remembers many times when he has gone at least twenty-four hours without a drink. It always seemed to be the worrying about tomorrow that eventually got him drunk.

"How about beer? Not even beer for an A.A.?"

There is no doubt about the answer. No beer. It isn't the form in which the first drink of alcohol is taken, or the quantity, that distinguishes John as an alcoholic, he is told. "Researchers are still trying to find all the answers to the problem of alcoholism but meantime, to the best of medical knowledge, if you are an alcoholic, you simply

can't take alcohol in any form," John's friends say. There just is no cure for alcoholism. Like diabetics, alcoholics can live satisfying, productive lives if they follow a few simple precautions. In A.A. the main precaution is to stay away from the first drink.

"Then alcoholism is like an illness?"

Yes, that's the most workable concept that seems to make sense. The alcoholic is primarily a sick person.

"How about those slogans? 'First things first.' 'Live and let live.' 'Easy does it.' Where do they come in?"

They are reminders, suggestions, symbols of the new kind of life the alcoholic can program for himself. "First things first" means that John won't be able to straighten out overnight all the problems created or aggravated by his drinking. He will have to take them one at a time, the most important ones first. "Live and let live" means that the alcoholic must beware of resentments that might disturb him to the point where he might want to try a drink. "Easy does it" is a reminder to relax, not to drive one's self beyond one's capabilities, and to be realistic in setting goals and objectives. It means that John should try to schedule his life a bit, even to the extent of getting adequate rest.

"WHAT WAS that 'A. A. prayer' one of the speakers mentioned?"

It is a very brief passage that many A.A. members refer to frequently in times of crisis: "God grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference." Try it, the sponsors suggest, it helps.

"Do I have to go to a lot of meetings like the one tonight?"

No one *has* to do anything in A.A. That goes for the most recent newcomer, like John, or for the oldest old-timer. John is free to drink if he chooses, and if he thinks it will solve anything. He is equally free *not* to drink, and the meetings provide recurring evidence that men and women who no longer want to drink can enjoy a life of sobriety. It's entirely up to John how many meetings he will attend. But experience shows that the men and women who are regular in their attendance rarely have relapses, or "slips." Those who skip too many meetings, particularly in the beginning, do not seem to be quite so lucky. The important thing is that the choice is John's.

"What is this 'Twelfth Step work' several people talked about?"

When two people came to John with the story of A.A., *that* was Twelfth Step work, as phrased in the last of the suggested Steps: "Having had a spiritual awakening . . . we tried to carry this message to alcoholics and practice these principles in all our affairs." It is an important means of strengthening the sobriety of people who may have been in A.A. for many years. And it is the one practical way that the sober person can express his

gratitude for the help he once received.

After his A.A. friends had left, John began to wonder whether or not he could actually stay sober. He felt fine, but did he have enough to fall back on if temptation should arise. He began to review what he had learned of the new fellowship he had joined, and what it had offered him.

It added up something like this:

A new concept of his problem. He was an alcoholic; a sick man, not necessarily a weak one.

A new circle of friends who obviously wanted to help him stay sober and who had assured him they would welcome his calls or visits and who had promised to keep in touch with him.

A new realization: "Once an alcoholic, always an alcoholic." And he had certainly admitted he was powerless over alcohol; he was an alcoholic.

A new understanding of the possibility that some Power greater than himself could help him. He did not have to *define* that Power, if he was unable to do so for the moment. But alcohol *had* definitely been a destructive power, where he was concerned. Certainly, there must be a constructive Power he could turn to. . . .

A new appreciation of a set of very old maxims. "First things first." "Easy does it." "Live and let live." Straight out of the copybooks, but . . . they did make sense.

A new set of A.A. literature, to help keep his mind on the new program he had turned to for help.

Yes, even a new prayer — clear and simple and full of common sense.

Perhaps, most important of all, the "Twenty-Four Hour Plan." This twenty-four hours was almost over, wasn't it? And he hadn't had a drink? And there was nothing he could do about yesterday, or tomorrow, was there?

Maybe it wasn't so difficult to stay sober in A.A., twenty-four hours at a time, after all!

This is the fourth in a series of articles relative to the fellowship of Alcoholics Anonymous, as prepared and released by General Service Headquarters of Alcoholics Anonymous.

Alcohol and Corrections

By DR. HOWARD JONES

IT HAS ALWAYS been assumed that there is a connection between drunkenness and crime, and this has often been supported by research. The nature of the connection also often seems quite clear from the research findings. Sturup and Christiansen, after estimating that nearly one-quarter of the inmates of a Danish state prison were drunk when they committed their crimes, found that the rates for the different kinds of offence varied from seventy-three per cent for aggressive offences to thirty per cent for stealing and zero per cent for embezzlement.[1] Mannheim, in England, has shown that arrests for drunkenness fell from about fifty per 1,000 in 1913 to about ten per 1,000 in the late 1930's,[2] and that this trend was paralleled by a decline in persons dealt with for assault from an annual average of 55,053 in 1900-09 to 18,537 in 1938.[3] The trend of these figures for Canada during the first half of this century shows much more fluctuation, but in spite of this, the curves for drunkenness and assault pursue a remarkably similar course.

The conclusion to be drawn from all this is an obvious and fairly common-sense one. Drunkenness appears to be associated with the more impulsive types of crime, the effect of alcohol being, presumably, to reduce the inhibitions which obstruct the free discharge of impulse into action. This would account for the close relationship between drunkenness and assault, for example; and also for the lack of correlation with crimes involving forethought and self-control — like embezzlement. Such a conclusion has obvious implications for the correctional services. If violent crime is very largely a problem of drunkenness, it must be tackled through the cure of the drunkard. The emphasis must be on the drink habit, rather than upon the violence.

Recent research, however, has thrown some doubt on this straightforward explanation. In any kind of statistical study (such as those cited above) one has to be aware of assuming that a statistical relationship between two phenomena necessarily means that one causes the other. They may not be casually related at all—that is, the statistical

correlation may be accidental. Or (and this is more likely) both kinds of phenomena may be caused by a single underlying cause. For example, instead of drink leading to crime, both may be evidence of an underlying psychopathological state. Thus an anti-social person may express his hostility towards society by rejecting its standards, either in getting drunk frequently or in committing crimes. And of course this would mean that many such would do both, thus establishing a statistical relationship between the two.

TYPICAL of a number of recent studies supporting this alternative point of view is that carried out by Pittman and Gordon in 1953-54 at Monroe County Penitentiary, Rochester, New York.[4] The records of 187 men imprisoned for public intoxication were analysed, and it was found that, although the criterion for their inclusion in the study had been conviction for drunkenness, they had had between them 691 arrests for non-inebriate offences — an average of nearly four per head, with many of course greatly exceeding that number. Moreover when their histories of arrest were explored, it was found that up to the age of 40, most of their offences had been of a non-inebriate kind, and only after 40 did drinking offences predominate. The fact that the non-inebriate offences came first certainly seems to disprove, in these cases at any rate, any theory that their crimes were the result of excessive drinking.

Pittman and Gordon argue that the evidence rather suggests that increased drinking replaces crime as a way of satisfying psychological needs, either because of advancing age, or because of persistent inability to gain satisfaction through success as a criminal. The idea, here, that one can be substituted for the other, is a direct illustration of the hypothesis that both derive from a basic need or abnormality, which is thus the true cause.

More research is required before the Pittman and Gordon theory can be regarded as established against its rivals. A project is at present developing in the University of Toronto (with the co-operation of the Governor of Toronto Gaol and of the Toronto Police). It is hoped that this may be expanded. But finance for the study of gaoled inebriates is less readily available than for inebriates in clinical treatment. Nevertheless, in any correctional system which sets treatment as its goal, an answer must be found to these questions. For they raise in an acute form the issue of what kind of disorder it is which the penal system has to treat.

THERE IS LITTLE doubt about the importance of these questions of causation for the correctional services. But there are aspects of the problem of the inebriate which are even more closely related to the correctional task. They arise mainly from the sheer size of the problem: the large number of intoxication cases which have to be dealt with by the service. In Canada, over the five years ending in 1955, the annual average number of convictions for intoxication was 89,238. This constituted an annual average rate of 878 per

100,000,[5] and was nearly five per cent of the rate of conviction for all offences. The number of convictions for drunkenness had risen steadily rising as high as 101,812 by 1956,[6] the last year for which published figures are available. They are by far the largest single group of offences, indictable or non-indictable, with the solitary exception of municipal traffic offences—a group of technical offences of little or no criminological significance.

Even adjudication on such a large number of cases is a tremendous task, and a city of any size, like Toronto, has to hold daily courts. Procedure in court is unavoidably hurried and cursory, and can have very little in common with a genuine diagnostic procedure, seeking to get to the root of the problem and to provide specific treatment. Routine sentencing formulae are the rule, the main emphasis being on simple deterrence. The defects of this procedure are obvious, but if there were any doubt about this it would be allayed by the high rate of recidivism among those appearing before the court for inebriate offences. Over one-half of them have been before the court for the same kind of offence several times in the course of the previous year, and a substantial number of them have very many previous convictions for drunkenness.

But the repercussions of the situation are almost certainly wider and more serious than this. The "drunks court", operating in this way, provides a focus for cynical and deterrent thinking within the judicial system which cannot do other than hinder the development of more progressive ideas in the treatment of crime generally. And it provides a heavy judicial burden, reducing both the time and the patience which magistrates are able to spare for diagnosis in non-inebriate cases. If intoxication cases could be removed from the calendars of the lower courts, it would be at least a step on the road towards re-orienting attitudes in those courts. As the lower courts deal with the great mass of offences, and also with many who are on the threshold of their criminal careers, anything which is likely to improve their diagnostic competence is much to be sought after, for its own sake. But it is very likely that its salutary effect would be felt in the higher courts too.

> THE EFFECT of this constant flood of convicted [inebriates] on the penal institution itself also deserves examination. It fills the gaols and prisons with transient prisoners who are there too short a time for the institution to provide them with re-educative treatment. And because they are so numerous they cause a major administrative problem in the institution at large, in arranging for their admission, induction, and discharge. Perhaps more important, but more difficult to assess, is their effect in delaying improvement in penal practice. Penal administrators often complain about the difficulty of either planning a training program or making it effective, if the institution contains a large floating population.
>
> There would seem to be a good case, on this ground alone, for ex-

cluding from the prison that part of its transient population which has been sentenced for drunkenness. The [inebriate] represents no real security risk, and can only be corrupted by the association with convicted criminals. If he is a true addict, moreover, the deterrent aspect of a prison sentence will have even less effect upon him than upon the criminal, and its power to restrain the latter is probably small enough.

In place of a prison sentence, the addict might be placed in a hostel, from which he could go out to work. This might be in association with probation, and be voluntary if possible, but compulsory if necessary. This would be similar to residence in hostels run by bodies like the Salvation Army but would differ from them in that there would be pressure on the [inebriate] to stay. Also provision would be made for treatment, of both a physical and psychological kind. It could also, incidentally, be a valuable centre for research. As the inmates would be going out to work and could therefore be expected to pay something towards their own maintenance, and as the security needs of such an institution would be so much less than those of a prison, it is very unlikely that the additional cost of such a plan, including treatment facilities, would be very great.

Such a scheme would help the prison, but it would also have many positive advantages on its own account. Treatment would be provided, and would be provided in a real-life setting, in which the social adjustment of the inmates could be both tested and worked with, instead of in the social vacuum of the closed penal institution. Also it would provide the alcohol addict with group support among others like himself. Recent research suggests he needs this and at present finds it in the Skid Row community. By skilled group handling, as in group psychotherapy, it should be possible to convert the social pressures of an alcoholic group of this kind into a positive instead of a negative influence. The imprisoning of large numbers of alcoholics together merely reproduces, in concentrated form, the existing, harmful Skid Row social pattern.

SEVERAL experiments along similar lines to this have been reported,[7] and show that the idea is workable. So far, only a relatively small proportion of those treated become capable of sustaining an independent existence in the world outside without alcohol (about twelve percent in one such experiment). But a much larger proportion seem able to live without alcohol, and to keep a job and enjoy many of the normal satisfactions of life, so long as they remain within the sheltered environment of the hostel. Limited though success has been with this latter group, their situation is incomparably better than it was when they were (to all intents and purposes) sheltering from life within the prison.

None of this, of course, helps to rid the courts of the incubus of the [inebriate]. A program of this kind should make for more optimism among magistrates, which will help

in the development of treatment attitudes. However, a real solution will probably call for something more radical. If [inebriates], after conviction in court, could be passed to a treatment authority (consisting of experts in social work, psychiatry, and medicine) for the actual sentence, it might provide an opportunity for testing-out this more modern approach to diagnosis for its wider application in the field of criminal diagnosis. And there is no doubt about the relief such a development would afford to the courts.

REFERENCES

1—Howard Jones. "Crime and the Penal System," 1957, p. 71.

2—Herman Mannheim. "Social Aspects of Crime between the Wars," 1940, p. 165.

3—"Ibid.", pp. 177-178.

4—D. J. Pittman and C. Wayne Gordon. "The Revolving Door," 1958.

5—R. E. Popham and Wolfgang Schmidt. "Statistics of Alcohol Use and Alcoholism in Canada." 1871-1956, p. 38.

6—Dominion Bureau of Statistics. "Statistics of Criminal and Other Offences," 1956.

7—D. J. Myerson, in Harold E. Himwich (ed.). "Alcoholism, Basic Aspects and Treatment," 1957, pp. 155 ff; E. Rubington: "The Chronic Drunkenness Offender," "Annals of the American Academy of Political and Social Science," January 1958, pp. 70 ff.

Dr. Howard Jones, a psychologist, returned to Leicester University, England, in the summer of 1959, after spending a year at the University of Toronto. This article is reprinted, by kind permission, from the October 1959 issue of the CANADIAN JOURNAL OF CORRECTIONS published by the Canadian Corrections Association, 55 Parkdale Avenue, Ottawa 3, Ontario, Canada.

MEDICAL

Hallucinogenic Drugs in the Treatment of Alcoholics

The "hallucinogenic" drugs mescaline and LSD-25 (d-lysergic acid diethylamide) produce in many persons not only perceptual disturbances but very intense emotional experiences. These drugs may induce an especially vivid awareness of deeply felt personality problems or an experience akin to that of sudden religious conversion. On occasion they may give rise to effects reminiscent of delirium tremens. In line with a number of observations on the value of these drugs as part of a program of psychotherapy, C. M. Smith (University Hospital, Saskatoon, Saskatchewan) has reported on a preliminary study of their use in the treatment of a group of 24 alcoholics. The experience of "hitting bottom" has been emphasized by Alcoholics Anonymous as an important preliminary to the acceptance of the new way of life represented by the A.A. program. Smith thought that the hallucinogenic drugs might make the patient "hit bottom" artificially and thereby render him sooner responsive to psychotherapy.

Twenty-four hospitalized alcoholic patients (23 men, 1 woman) were selected for the study. All of them were considered to be difficult cases with unfavorable prognoses. Half of the patients were diagnosed as psychopaths; 8 were classified as having character disorders and 4 were considered to be either psychotic or on the borderline of psychosis. The average number of years of uncontrolled drinking was 12. All but 4 of these patients had tried the Alcoholics Anonymous program and had failed to achieve sobriety through it. Eight patients had had at least one attack of delirium tremens, and other complications of alcoholism were present in all except two.

Since the establishment of good rapport was considered to be of great importance for the success of the experiment, the first phase of the study, lasting 2 to 4 weeks, was devoted to the building up of a psychotherapeutic relationship and to the assessment of each patient's main problems. The patient was then given a single dose of either mescaline or LSD-25 by mouth. Since alcoholics tend to be remarkably resistant to the hallucinogens, the amounts administered were between 200 and 400 micrograms of LSD-25 or 0.5 gram of mescaline. In

the average subject much smaller doses suffice to produce a comparable reaction.

While the patient was under the influence of the drug, a prolonged interview with him was carried out by the psychiatrist. At no time was the patient left alone and no attempt was made to arouse fear. Rather, discussion was focused on the problems which had led the patient to his drinking and those which arose out of it. In addition, strong positive suggestions were made to the patient that he discontinue drinking. The psychological effects of the drug lasted between 8 and 9 hours, on the average, and all the patients reported feeling well on the following day. While a transient nausea was reported by many patients, side effects of the drugs were minimal. In the days following the experiment, further discussions, based on the material which had emerged under the influence of the drug, were held with each patient. Soon after this the patient was discharged from the hospital.

In evaluating the results of this preliminary study of the hallucinogens, Smith emphasizes that the effect of the drugs cannot be considered apart from the rest of the treatment regimen. Nevertheless he considers these drugs a promising adjunct in the treatment of alcoholism and the results of their use encouraging enough to warrant further trials and study of their contribution to the advancement of recovery. On the basis of follow-up data, half of the 24 refractory patients studied were classified as either "much improved" or "improved." The other half were considered "unchanged." No patient became worse as a result of the experience. The drugs seemed to be of least value for the psychotic or borderline psychotic patients (3 out of 4 were "unchanged") and of most value for the patients in the group of character disorders (7 out of 9 showed improvement).

Unless severe anxiety was aroused by the effect of the drug and communication with the therapist blocked, the patients who had an intense reaction seemed to be more favorably affected than those who had a mild one. Many of the alcoholics seemed to gain increased understanding of themselves from the dramatic disturbance induced by the drug, an understanding which appeared to influence their later behavior in the direction of sobriety.

Until experience with a new drug accumulates from many experiments, all judgments of its value must be highly tentative. Smith draws the conclusion, from the results of his pilot study, that the possible role of the hallucinogens as a useful adjunct in the treatment of alcoholism is worth careful systematic investigation. He suggests that with a less refractory group of patients these drugs might prove to be valuable clinical tools.

REFERENCE

SMITH, C. M. A new adjunct to the treatment of alcoholism: the hallucinogenic drugs. Quart. J. Stud. Alc. 19:406-417, 1958.

ANNUAL MEETING

The Seventh Annual Board and Membership meeting of The Alcoholism Foundation of Alberta was held at the Foundation offices, Edmonton, May 18th, 1960. Mr. S. A. Keays, President for the past two years presided. The Officers and Board of the Foundation are as follows:

Mr. D. S. Macdonald, Edmonton, President
Mr. G. L. Crawford, Calgary, Vice-President
Mr. R. W. Burns, Calgary, Vice-President
Mrs. C. R. Wood, M.L.A., Stony Plain, Honorary Secretary
Mr. John S. McGuckin, Edmonton, Honorary Treasurer
Honorable Dr. J. Donovan Ross, Honorary Board Chairman
Magistrate R. E. Baynes, Grande Prairie
Mr. George Cristall, Calgary
Mr. J. B. Cross, Calgary
Mr. S. A. Keays, Edmonton
Dr. Walter C. MacKenzie, Edmonton
Mr. Wm. Newbigging, Edmonton
Dr. R. M. Parsons, Red Deer
Mr. C. W. Ross, Edmonton
Justice S. Bruce Smith, Edmonton
Mr. Murray E. Stewart, Edmonton
Mrs. W. C. Taylor, Wainwright
Dr. S. Thorson, Calgary
Hon. Norman A. Willmore, Edmonton
and Honorable E. C. Manning—Honorary Board Member.

Retiring President, Mr. S. A. Keays, expressed his gratitude to all Board members, staff members, and others who had made his term of office so personally gratifying. He expressed his appreciation and sense of accomplishment at leaving the office of President with so many planned activities now realized. He then read his report as contained in the Sixth Annual Progress Report.

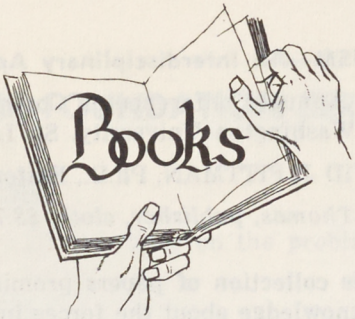
The Honorable Dr. J. Donovan Ross, Honorary Board Chairman, on behalf of the membership and Board of the Foundation, paid special tribute to Dr. John W. Scott, former Dean of Medicine of the University of Alberta, who had chaired the Medical Advisory Committee and served as one of the organizers of the Foundation. This committee is now chaired by Dr. Walter C. MacKenzie, Dean of the School of Medicine, University of Alberta.

The Executive Director, Mr. J. George Strachan, reviewed the expansion of activities both in the major centres of Edmonton and Calgary and the communities of Lethbridge, Medicine Hat, Grande Prairie, and Peace River. He commended the many people from government, business, and industry, who had done so much to support the work of the Foundation.

Mrs. C. R. Wood moved a vote of thanks to the outgoing Officers and Executive Committee Members. Retiring members of the Board were:

Dr. John W. Scott
Rev. G. B. Switzer
Mr. Vernon Taylor

Dr. E. M. Jellinek addressed the meeting on "Goals in Alcoholism Programming" which is reprinted in this issue of Progress.



Alcohol Education for the Layman

A Bibliography, Selected and Annotated by

MARGARET E. MONROE, and JEAN STEWART

Rutgers University Press, $5.00

This useful bibliography was prepared by the Graduate School of Library Service, Rutgers, The State University, under a grant from the United States Brewers' Foundation. It lists books, films, and pamphlets on alcohol and alcoholism, and should be invaluable to the librarian and to the interested layman. The book contains a detailed subject index, an author-title index, and, particularly useful to the librarian, recommendations of possible users of each item listed.

Drinking and Intoxication

RAYMOND G. McCARTHY, Editor

Publications Division: Yale Center of Alcohol Studies

The Free Press, $7.50

This attractively produced and illustrated book consists of 32 chapters, by almost as many authors, on man's use of alcohol and alcohol's effect on man. The first section is on the Physiological and Psychological Effects of Alcohol, following which are sections on Drinking Practices, Ancient and Modern; Drinking Practices, U.S.A.; Cultural, Religious, and Ethnical Factors; and Controls. There is a separate short chapter on Canadian Drinking Customs by Robert E. Popham.

ALCOHOLISM—An Interdisciplinary Approach

(Proceedings of the First Annual Conference on Community Mental Health; Social Science Institute, Washington University, St. Louis, Missouri, 1959.)

DAVID J. PITTMAN, Ph.D., Editor

C. C. Thomas, publisher, cloth, $3.75

The Foreword to this collection of papers promises ". . . a statement of the present status of knowledge about the forces involved in the appearance and course of alcoholism . . . (and) a platform from which the research scientist can launch further investigation of this phenomenon."

This goal entails perhaps unreasonably high expectations for a first annual conference. In this reader's opinion the promised statement and platform is fragmentary and incomplete; hardly justifying the claim that this is, "The FIRST and ONLY work in the field to provide a *current summary* of the status of research in alcoholism from the perspectives of *psychiatry, psychology, sociology* and *physiology.*"

Section I of this publication includes papers entitled: Psychiatric Research in the Etiology of Alcoholism; Psychological Considerations in the Etiology of Alcoholism; A Sociological View of the Etiology of Alcoholism; and An Overview of the Physiological Research in Alcoholism—arranged, perhaps, not coincidentally, in ascending order of merit.

The last mentioned paper by Dr. Ebbe C. Hoff shares honors for interest and exposition with the Editor's concluding review: Interdisciplinary Considerations in Alcoholism.

Section II contains Summary reports of Conference sub-group discussions. As is often the case in such resumés, a wide diversity of opinion — some of it quite provocative and pertinent—is cautiously submitted to reflect the consensus of opinion without offending individual dissenters. Again the effect is fragmentary and incomplete; sometimes repetitious, sometimes contradictory.

Particular praise must be afforded the Conference objectives, and it must be conceded that in this book one catches glimpses of views well worth repeated examination.

Those who share the view that well-planned, co-ordinated, co-operative interdisciplinary research is practical and essential to rapid advances in the field will look forward to further reports on the Social Science Institute's initiative—perhaps published in somewhat less pretentious form.

W. E. WILBY.

OTHER FOUNDATION SERVICES

- **ADVISORY SERVICES:**

  Professional advice and assistance on the problems of alcoholism.

- **AUDIO-VISUAL AIDS:**

  Films, tapes, records, and displays are available on loan.

- **CONFERENCES and SEMINARS:**

  To create a better understanding of the problems of alcoholism and methods of dealing with those problems.

- **INDUSTRIAL WORKSHOPS:**

  For the education of management, supervisory staffs, and general employees in Alberta industry.

- **ORIENTATION PROGRAMS:**

  For nurses, doctors, internes, penal officials, personnel managers, social workers, clergymen, teachers, and other groups.

- **PUBLICATIONS:**

  Progress, News Review, Digest on Alcohol Studies, and original brochures and pamphlets.

- **REFERENCE LIBRARY:**

  Books, pamphlets, and publications by authorities in the field of alcoholism.

- **SPEAKERS' BUREAU:**

  For professional, industrial, church, social, school, civic, and other groups requesting information.

The illustrations in Progress are by Harry Heine

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